TO THE EDITOR, *Genitourinary Medicine*

Intralesional interferon alpha-2b in treating refractory meatal and anal warts

Sir,

Previous studies have shown that intralesional injection of interferon alpha-2b (Intron A, Schering Corp.) 1×10^6 IU three times a week for three weeks is effective in reducing the size and numbers of genital warts.[1,2] These controlled studies have, however, focused on the treatment of one to three selected externally located genital warts.

Refractory warts are often located in the urethra and anal canal. We used the above regimen to treat 10 male patients who had had warts for more than one year. Five had anal warts (four to five warts a patient), and five had meatal warts (one to two warts a patient). The patients had previously received conventional treatment, including podophyllin, electrocautery, cryotherapy, and laser surgery. None had antibodies against human immunodeficiency virus. To reduce the systemic adverse reactions to interferon, all patients were treated with 1·3 g acetaminofen on each day of injection.

After an observation period of 12 weeks, cure was obtained in five patients (three with meatal warts and two with anal warts). A 50% or more reduction in the size of the warts was seen in two. Minimal influenza like symptoms were seen initially in five. A reversible decrease in the numbers of leucocytes was seen in all patients, but none became leucopenic. No other biochemical abnormalities were detected.

We conclude that intralesional injection of interferon alpha-2 b may be a suitable way of treating refractory warts located in the urethra and the anal canal.

Yours faithfully,
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References

1. Vance IC, Bart BJ, Hansly RC, *et al.* Intralesional recombinant alpha-2 interferon for the treatment of patients with condyloma acuminata or veruca plantaris. *Arch Dermatol* 1986;**122**:272-7.
2. Eron JL, Judson F, Tucker S, *et al.* Interferon therapy for condylomata acuminata. *N Engl J Med* 1986;**315**:1059-64.

TO THE EDITOR, *Genitourinary Medicine*

Risk of AIDS after rape

Sir,

We are grateful to Dr Kay for his comments on our paper "Incidence of sexually transmitted diseases in rape victims during 1984" (*Genitourin Med* 1987;**63**:62), in which the risk of acquiring human immunodeficiency virus (HIV) was not discussed. Women who have been raped are left anxious and psychologically helpless. They have to go through a grieving process for their particular loss. By adding the fear of infection with HIV to their anxiety, one is encouraging non-resolution of their psychological trauma. In 1984, we felt that it would have been unethical to raise the fear of the acquired immune deficiency syndrome (AIDS) in these women. At that time, there was almost no evidence of AIDS in female partners of infected men in the UK, Europe, or the USA.

When the risk of acquiring AIDS after rape is small, but present, as it is now, researchers will have to consider ethical ways of screening without causing unnecessary anxiety to patients. Concern about acquiring AIDS or HIV infection may be the only reason for a woman's attendance at a department of genitourinary medicine following rape. In patients who are very distressed at their initial attendance, and for whom it does not seem to be appropriate to discuss HIV, sera may be taken at three monthly intervals and stored for subsequent testing. This protocol would fit in with recommended patient review to exclude the development of other sexually transmitted diseases, such as syphilis and hepatitis B.

HIV is transmitted via blood and semen. Sexual dysfunction occurs during rape.[1] The alleged rapist may ejaculate before intromission or fail to ejaculate, though the victim may be unaware that this has occurred. Risk of HIV transmission will be lessened if sexual dysfunction has occurred. Furthermore, Jones *et al* found that only three of 36 regular sexual partners of seropositive patients with haemophilia A were themselves seropositive.[2] There was a contributory factor of a blood transfusion in one woman. The length of the relationship, contraceptive usage, and type of coitus practised were not discussed.

It seems reasonable to conclude at the moment, however, that the risk of acquiring HIV after rape remains low, but should be considered.

Yours faithfully,
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References

1. Groth AN, Burgess AW. Sexual dysfunction during rape. *N Engl J Med* 1977;**297**:764.
2. Jones P, Hamilton PJ, Bird G, *et al.* AIDS and haemophilia: morbidity and mortality in a well defined population. *Br Med J* 1985;**291**:695-9.

TO THE EDITOR, *Genitourinary Medicine*

Is *Entamoeba histolytica* in homosexual men a pathogen?

Sir,

We would take issue with Dr Scott's summary (*Genitourin Med* 1986;**62**:365) of our paper "Is *Entamoeba histolytica* in homosexual men a pathogen?" (*Lancet* 1986;i:641-4).

He stated in his penultimate paragraph that we found "improvement in proctitis after treatment" (for *E histolytica).* In fact the reverse obtained. Patients who still harboured this protozoan showed a greater improvement in rectal inflammation histologically than the men from whom *E histolytica* was eradicated. He went on to point out the differences between our test and control groups, compared with McMillan's test and control groups. We endeavoured to make the two groups as similar as possible with the exception of the test variable (presence of *E histolytica*), whereas McMillan, we feel incorrectly, was content to have appreciably different histories of diarrhoea in his test and control groups.

Though we sympathise with Dr McMillan and his colleagues and accept that it is difficult to have well matched test and control groups, we feel that their control group was biased in many respects.

Finally, we feel at a loss to know what non-specific proctitis, whatever that means, has to do with whether *E histolytica* is a pathogen or not. Quite simply *E histolytica* that has produced disease in the colon causes invasion of the mucosa. This in turn produces acute proctocolitis and serum antibody to *E histolytica*. Trophozoites of *E histolytica* are invariably found in mucus or faeces from such patients. None of these changes were found in any of our patients, perhaps with the exception of a few with histologically con-

firmed acute proctitis. The zymodemes we found are those that produce no disease in parts of the world with endemic amoebiasis. Where is the evidence for invasion? McMillan and his colleagues postulated a toxin derived from *E histolytica* causing symptoms. Our work showed no cytotoxin of any sort in our patients harbouring *E histolytica* in their bowels.

Yours faithfully,
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Correction

Control of hepatitis B and human T lymphotropic virus type III (HTLV-III) in homosexuals in Sheffield

This letter (*Genitourin Med* 1986;**62**:206) contained data from the department of genitourinary medicine of the General Infirmary, Leeds, by kind permission of Dr M Waugh. An acknowledgement of this was omitted in error.

Book review

Clinical aspects of AIDS and AIDS-related complex. Staquet M, Hemmer R, Baert A, eds, 1986. Oxford: Oxford University Press. Pp 209 including index. Price £25 (hardback).

This is a well produced book based on a symposium held in Belgium in October 1985. The papers are of uniformly high standard and the editors have ensured uniformity of style, though they understandably had to allow the introductions to each paper to be somewhat repetitive.

The first section deals with clinical presentations, clinical epidemiology, and natural history. Most accounts are descriptive and confirm previously held suspicions concerning the extent and nature of the problems. As one paper stated, almost on behalf of the others, "the clinical features observed are similar to those reported from elsewhere."

The second section deals with the infections seen in the acquired immune deficiency symdrome (AIDS), and comprises a review, fungal infections, aspects of mycobacterial infections seen in the United Kingdom, preliminary results of treatment for central nervous system toxoplasmosis, and treating patients with AIDS and crytposporidiosis with interferon and interleukin-2.

The third section deals with clinical immunology, laboratory tests, and "diagnostics", and includes a useful paper on the diagnostic and prognostic value of lymph node biopsy.

The fourth section deals with treatment, and comprises reports on the use of interferon, interleukin-2, suramin (two papers), and DHPG (RS2192). Three of the five paper titles contain the qualification "preliminary", which adds to their interest and simultaneously suggests that by the time you read this review (or the book) more relevant information will be available. Interestingly there is some debate about the side effects of suramin, which "are similar to those already published in the treatment of onchocerciasis" (p 192), but on page 186 "these side effects, in our experience and that of others, seldom occur in the treatment of onchocerciasis". Such contradictions almost certainly reflect the problems of comparing relatively small trials derived from different population groups in differing stages of infection with human immunodeficiency virus (HIV): if the side effects are different this suggests that it would be even more difficult to draw generally relevant conclusions about treatment results from either study: more work is required.

If you require a review of all aspects of AIDS there are more integrated accounts available, and if you want up to date information and trial results there are the journals. As this book fulfills neither role and costs £25, I cannot judge it to be a good buy: it would have been an ideal journal supplement.

P D Welsby

Notices

Organisers of meetings who wish to insert notices should send details to the editor (address on the inside front cover) at least eight months before the date of the meeting or six months before the closing date for applications.

Sixth Latin American congress of sexually transmitted diseases

The sixth Latin American congress of sexually transmitted diseases will be held on 16 to 18 September 1987 in Guayaquil, Ecuador. It will be preceded by a theoretical and practical course on "The laboratory in the diagnosis of sexually transmitted diseases", which will be held on 14 and 15 September.

For further information please contact Dr J Felipe Aroca Campodonico, President of UECETS, Casilla 4733, Guayaquil, Ecuador.

5th Forum of international andrology *(note new date)*

The 5th forum of international andrology will be held in Paris on 6–8 July 1987. Subjects will include male impotence, puberty and andropause, tumours of the testis, penile curvatures, urethritis, artificial insemination, and anti-androgens.

For further information please contact: Professor G Arvis, Department of Andrology-Urology, Hopital Saint-Antoine, 184 rue du Faubourg Saint-Antoine, F-75012 Paris, France (Tel: (1) 43 43 73 40, Telex: ARVIS 250 303 PUBLIC PARIS).